



IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

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|----------------------------------|---|--|
| Re Application of: James P. Elia |) | |
| |) | Group Art Unit: 1646 |
| Serial No.: 09/064,000 |) | |
| |) | Examiner: Elizabeth C. Kemmerer, Ph.D. |
| Filed: April 21, 1998 |) | |
| |) | |
| For: METHOD FOR GROWTH |) | |
| OF SOFT TISSUE |) | |

**SUPPLEMENTAL DECLARATION
OF ANDREW E. LORINCZ, M.D.**

I Andrew E. Lorincz declare as follows:

1. I reside at 13820 NW County Rd 235, Apt 8, Alachua, FL 32616-2098.
2. This Supplemental Declaration is submitted in addition to my previously submitted Declaration in this application, dated February 12, 2001, and makes no changes to such previous Declaration.
3. My Curriculum Vitae is attached as Exhibit A to my previous Declaration.
4. In addition to the information set forth in my CV, I provide the following information:

I am familiar with stem cell technology, including bone marrow preparation.

Several publications involving cells are included in my CV; namely, Fluorescent Microscopy of DES-induced Morphologic Transformation in Unfixed, Cultured Cells and Biochemical Genetic Defects.

I performed an unreported study involving assessing stem cell infusion into patients to correct Hurler's Syndrome by transplanting cord blood stem cells. My CV is replete with references to Hurler's Syndrome, as well as other cellular studies.

I am currently Chairman of Vitalflor, a company involved in the observation of cells in the microscopy of vitally stained living organisms, including cells. In this regard, I was granted U.S. Patent Nos. 5,812,314; 6,239,906 B1; and 6,567,214 B2, all of which relate to special stains useful in assessments.

5. I have read and understood the disclosures of the above-referenced patent application at page 20, line 10 through page 21, line 15; at page 37, lines 19-25; at page 44, line 19 through page 46, line 16; and at page 47, line 22 through page 48, line 15. A copy of such disclosures is attached hereto as Exhibit A.
6. I note that the disclosures referenced in above Paragraph 5 relate to using a growth factor for promoting the growth of soft tissue, and more specifically, to a method of using a cell, such as a stem cell, to grow soft tissue, such as an artery.
7. I am aware of and have considered the definition of *growth factor* in the specification of the above-referenced patent application at page 20, line 10 through page 21, line 15. Such definition is set forth in Exhibit B. Also included in Exhibit B is a definition from the medical dictionary, MEDLINE plus: Merriam-Webster Medical Dictionary, a service of the U.S. NATIONAL LIBRARY OF MEDICINE and the NATIONAL INSTITUTES OF HEALTH. I find that the dictionary definition is consistent with that contained at page 20, line 10 through page 21, line 15 of the above-referenced patent application. I believe

that both definitions are appropriate for use in the field of tissue growth and would be understood by one skilled in the medical arts. Accordingly, I am adopting and utilizing the definition contained in the patent application throughout this declaration.

8. I have read and understood the claims set forth in Exhibit C and have been informed that such claims are present in the above-referenced patent application. It is my opinion that those skilled in the medical arts, reading such claims would understand that cells including stem cells, are species of living organisms.
9. The publication in attached Exhibit D illustrates that placement of a growth factor, including cells, and more specifically, stem cells, in a human patient forms soft tissue, such as an artery. This publication reports work performed by reputable, skilled scientists and reputable organizations in the medical arts. Consequently, I believe that these reports would be recognized as clearly valid by one of ordinary skill in the medical arts because they report the results of scientific tests conducted by competent, disinterested third parties with use of proper scientific controls.
10. Based upon above Paragraphs 5-9, it is my opinion that introducing a growth factor, including cells, and more specifically, stem cells, in the body of a human patient will predictably result in the growth of soft tissue, such as an artery.
11. Based upon above Paragraphs 5-8, it is my opinion that one skilled in the medical arts, armed with the knowledge in such paragraphs, would be able to practice the method set forth in Exhibit C without need for resorting to undue experimentation.
12. Declarant states that the above opinion was reached independently.

Declarant understands that (1) any willful false statements and the like made herein are punishable by fine or imprisonment, or both (18 U.S.C. 1001) and may jeopardize the validity of the application or any patent issuing thereon, and (2) that all statements made of Declarant's own knowledge are true and that all statements made on information and belief are believed to be true.

Further Declarant sayeth not.

Date: 11-8-04

Andrew E. Lorincz
Andrew E. Lorincz



SUPPLEMENTAL EXHIBIT A

DISCLOSURES APPLICATION SERIAL NO. 09/064,000

PAGE 20, LINE 10 – PAGE 21, LINE 15

Growth factors can be utilized to induce the growth of “hard tissue” or bone and “soft tissues” like ectodermal and mesodermal tissues. As used herein, the term growth factor encompasses compositions and living organisms which promote the growth of hard tissue, such as bone, or soft tissue, in the body of a patient. The compositions include organic and inorganic matter. The compositions can be genetically produced or manipulated. The living organisms can be bacteria, viruses, or any other living organism which promote tissue growth. By way of example and not limitation, growth factors can include platelet-derived growth factor (PDGF), epidermal growth factor (EGF), fibroblast growth factor (acidic/basic (FGF a,b), interleukins (IL’s), tumor necrosis factor (TNF), transforming growth factor (TGF-B), colony-stimulating factor (CSF), osteopontin (Eta-1 OPN), platelet-derived growth factor (PDGF), interferon (INF), bone morphogenic protein 1 (BMP-1), and insulin growth factor (IGF). Recombinant and non-recombinant growth factors can be utilized as desired. Bacteria or viruses can, when appropriate, be utilized as growth factors. For example, there is a bacterial hydrophilic polypeptide that self-assembles into a nanometer internal diameter pore to build a selective lipid body. Various enzymes can be utilized for the synthesis of peptides which contain amino acids that control three-dimensional protein structure and growth. Growth factors can be applied in gels or other carriers which regulate the rate of release of the growth factors and help maintain the growth factors and the carrier, at a desired location in the body. Time release capsules, granules, or other carriers containing growth factor can be activated by tissue pH, by enzymes, by ultrasound,

by electricity, by heat, by selected *in vivo* chemicals or by any other selected means to release the growth factor. The carrier can be resorbable or non-resorbable. Or, the growth factor itself can be activated by similar means. Either the carrier or the growth factor can mimic extracellular fluid to control cell growth, migration, and function. The growth factor can be administered orally, systemically, in a carrier, by hypodermic needle, through the respiratory tract, or by any other desired method. The growth factor can also be administered into a capsule or other man-made composition or structure placed in the body. While administration of the growth factor is presently usually localized in the patient's body, circumstances may arise where it is advantageous to distribute a growth factor throughout the patient's body in uniform or non-uniform concentrations. An advantage to growth factors is that they can often, especially when in capsule form or in some other containment system, be inserted to a desired site in the body by simply making a small incision and inserting the growth factor. The making of such small incision comprises minor surgery which can often be accomplished on an out-patient basis. The growth factors can be multifactorial and nonspecific.

PAGE 37, LINES 19-25

Multifactorial and nonspecific cells (such as stem cells and germinal cells) can provide the necessary *in vivo* and *in vitro* cascade of genetic material once an implanted master control gene's transcription has been activated. Likewise, any host cell, clone cell, cultured cell, or cell would work. Genetic switches (such as the insect hormone ecdysone) can be used to control genes inserted into humans and animals. These gene switches can also be used in cultured cells or other cells. Gene switches govern whether a gene is on or off making possible precise time of gene activity.

PAGE 44, LINE 19 – PAGE 46, LINE 16

Genetic material comprising a portion of a gene, a gene, genes, a gene product (i.e., a composition a gene causes to be produced like, for example, an organ-producing growth factor), growth factor, or an ECM (extracellular matrix) can be used in or on the body to grow an organ to tissue. For example, the vascular epithelial growth factor gene (VEGF) or its growth factor equivalent can be inserted into the body to cause an artery to grow. When insertion of a gene, portion of a gene, gene product, growth factor, or ECM *in vivo* or *ex vivo* is referred to herein in connection with any of the implant techniques of the invention, it is understood that a cell nutrient culture(s), physiological nutrient culture(s), carrier (s), enhancer(s), promoter(s), or any other desired auxiliary component(s) can be inserted with the gene or at the same location as the gene, growth factor, ECM, etc.

An artery is an organ from the circulatory system. An artery can be grown in the heart, legs, or other areas by injecting a gene or other genetic material into muscle at a desired site. Size, vascularity, simplicity of access, ease of exploitation, and any other desired factors can be utilized in selecting a desired site. The gene is one of several known VEGF genes which cause the production of vascular endothelial growth factors. Several VEGF genes which produce vascular endothelial growth factors are believed to exist because nature intends for there to be several pathways (i.e., genes) which enable the production of necessary growth factors. The existence of several pathways is believed important because if one of the genes is damaged or inoperative, other similar genes can still orchestrate the production of necessary growth factors. VEGF genes are used by the body to promote blood vessel growth. VEGF genes are assimilated (taken in) by muscle cells. The genes cause the muscle cells to make a VEGF protein which

promotes the growth of new arteries. VEGF proteins can be made in a lab and injected into a patient intravenously, intraluminally, or intramuscularly to promote the growth of an artery. Or, the genes (or other genetic material) can be applied with an angioplasty balloon, with the assistance of a vector, or by any other method.

It is not always desirable to grow a completely new organ. Sometimes growing a portion of an organ is desirable. For example, in some heart attacks or strokes, a portion of the heart or brain remains viable and a portion dies. An injection of a gene to form cardiac muscle and/or an injection of a gene to form an artery can be utilized to revive or replace the dead portion of the heart. The dead portion of the heart may (or may not) be used as a matrix while the new muscles and vessels grow. Thus, in this example, a partial new organ is grown in a pre-existing organ. A pacemaker may (or may not) be necessary. A second injection of a gene may (or may not) be necessary to stop cardiac muscle growth once it is completed. Portions of organs throughout the body can similarly be repaired or replaced. It may be necessary to provide gene(s) or growth factor(s) sequentially. For instance, one or more blood vessels are grown by inserting an appropriate gene or other genetic material into a selected area. Second, an appropriate gene or other genetic material is inserted in the selected area to grow a bone or other organ.

The size and shape limitation of the desired structure can come from a containment and boundary contact inhibition phenomenon or by a chemical inhibition.

A variation on the theme of growing a portion of an organ is as follows: a portion of a heart dies. The pericardium is utilized as a scaffold and seeded with cells and/or genes to grow new muscle, and genes (or other genetic material) to grow new arteries. Immediately adjacent the dead cardiac muscle, onto or into the pericardium, the appropriate cells, genes, and/or growth factors (or other genetic material) are placed. Once the new muscle and blood vessels have

grown, the function specific tissue can be applied to the damaged portion of the heart and paced, if necessary, to augment cardiac action. If the surgeon desires, the dead muscle can be removed and the new muscle and blood vessels can be surgically rotated into the excised region and secured. This probably can be done endoscopically. In essence, the pericardium is utilized to allow the new muscle wall to grow. The new muscle wall is then transplanted into the damaged heart wall. This procedure utilizes the body as a factor to grow an organ and/or tissue, after which the organ and/or tissue is transplanted to a desired region. On the other hand, the new muscle wall may integrate itself into the old wall and not require transplantation.

PAGE 47, LINE 22 – PAGE 48, LINE 15

Organs and/or tissues can be formed utilizing the patient's own cells. For example, a skin cell(s) is removed from the intraoral lining of a cheek. The cell is genetically screened to identify DNA damage or other structural and/or functional problems. Any existing prior art genetic screening technique can be utilized. Such methods can utilize lasers, DNA probes, PCR, or any other suitable device. If the cell is damaged, a healthy undamaged cell is, if possible, identified and selected. If a healthy cell can not [sic] be obtained, the damaged cell can be repaired by excision, alkylation, transition or any other desired method. A growth factor(s) is added to the cell to facilitate dedifferentiation and then redifferentiation and morphogenesis into an organ or function specific tissue. Any machine known in the art can be used to check the genetic fitness of the organ and its stage of morphogenesis. A cell nutrient culture may or may not be utilized depending on the desired functional outcome (i.e., growth of an artery, of pancreatic Islet cells, of a heart, etc.) or other circumstances. Replantation can occur at any appropriate stage of morphogenesis. The foregoing can be repeated without the patient's own

cells if universal donor cells such a [sic] germinal cells are utilized. Germinal cells do not require a dedifferentiation. They simply differentiate into desired tissues or organs when properly stimulated. Similarly, the DNA utilized in the foregoing procedure can come from the patient or from any desired source.

During reimplantation one of the patient's own cells is returned to the patient. During implantation, a cell not originally obtained from the patient is inserted on or in the patient.

In the example above, if germinal cells (and in some case, stem cells) are utilized a direct differentiation and morphogenesis into an organ can occur in vivo, ex vivo, or in vitro.



SUPPLEMENTAL EXHIBIT B

DEFINITIONS

PAGE 20, LINE 10 – PAGE 21, LINE 15

Growth factors can be utilized to induce the growth of “hard tissue” or bone and “soft tissues” like ectodermal and mesodermal tissues. As used herein, the term growth factor encompasses compositions and living organisms which promote the growth of hard tissue, such as bone, or soft tissue, in the body of a patient. The compositions include organic and inorganic matter. The compositions can be genetically produced or manipulated. The living organisms can be bacteria, viruses, or any other living organism which promote tissue growth. By way of example and not limitation, growth factors can include platelet-derived growth factor (PDGF), epidermal growth factor (EGF), fibroblast growth factor (acidic/basic (FGF a,b), interleukins (IL’s), tumor necrosis factor (TNF), transforming growth factor (TGF-B), colony-stimulating factor (CSF), osteopontin (Eta-1 OPN), platelet-derived growth factor (PDGF), interferon (INF), bone morphogenic protein 1 (BMP-1), and insulin growth factor (IGF). Recombinant and non-recombinant growth factors can be utilized as desired. Bacteria or viruses can, when appropriate, be utilized as growth factors. For example, there is a bacterial hydrophilic polypeptide that self-assembles into a nanometer internal diameter pore to build a selective lipid body. Various enzymes can be utilized for the synthesis of peptides which contain amino acids that control three-dimensional protein structure and growth. Growth factors can be applied in gels or other carriers which regulate the rate of release of the growth factors and help maintain the growth factors and the carrier, at a desired location in the body. Time release capsules, granules, or other carriers containing growth factor can be activated by tissue pH, by enzymes, by ultrasound,

by electricity, by heat, by selected *in vivo* chemicals or by any other selected means to release the growth factor. The carrier can be resorbable or non-resorbable. Or, the growth factor itself can be activated by similar means. Either the carrier or the growth factor can mimic extracellular fluid to control cell growth, migration, and function. The growth factor can be administered orally, systemically, in a carrier, by hypodermic needle, through the respiratory tract, or by any other desired method. The growth factor can also be administered into a capsule or other man-made composition or structure placed in the body. While administration of the growth factor is presently usually localized in the patient's body, circumstances may arise where it is advantageous to distribute a growth factor throughout the patient's body in uniform or non-uniform concentrations. An advantage to growth factors is that they can often, especially when in capsule form or in some other containment system, be inserted to a desired site in the body by simply making a small incision and inserting the growth factor. The making of such small incision comprises minor surgery which can often be accomplished on an out-patient basis. The growth factors can be multifactorial and nonspecific.

MEDLINE PLUS: MERRIAM-WEBSTER MEDICAL DICTIONARY
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NATIONAL INSTITUTES OF HEALTH

Growth factor: a substance (as a vitamin B₁₂ or an interleukin)
that promotes growth and especially cellular growth



SUPPLEMENTAL EXHIBIT C

CLAIMS APPLICATION SERIAL NO. 09/064,000

382. A method for producing a desired soft tissue in a body of a human patient comprising:
- (a) Placing cells in said body of said human patient;
 - (b) Forming a bud in said body of said human patient; and
 - (c) Growing said desired soft tissue from said bud.
383. The method of claim 382, wherein said cells are multifactorial and non-specific.
384. The method of claim 383, wherein said cells comprise stem cells.
385. The method of claim 382 further comprising forming a new artery.
386. The method of claim 383 further comprising forming a new artery.
387. The method of claim 382, wherein said soft tissue comprises mesodermal tissue.
388. The method of claim 382, wherein said soft tissue comprises an artery.

Clinical Investigation and Reports

Repair of Infarcted Myocardium by Autologous Intracoronary Mononuclear Bone Marrow Cell Transplantation in Humans

Bodo E. Strauer, MD; Michael Brehm, MD; Tobias Zeus, MD; Matthias Köstering, MD; Anna Hernandez, PhD; Rüdiger V. Sorg, PhD; Gesine Kögler, PhD; Peter Wernet, MD

Background—Experimental data suggest that bone marrow–derived cells may contribute to the healing of myocardial infarction (MI). For this reason, we analyzed 10 patients who were treated by intracoronary transplantation of autologous, mononuclear bone marrow cells (BMCs) in addition to standard therapy after MI.

Methods and Results—After standard therapy for acute MI, 10 patients were transplanted with autologous mononuclear BMCs via a balloon catheter placed into the infarct-related artery during balloon dilatation (percutaneous transluminal coronary angioplasty). Another 10 patients with acute MI were treated by standard therapy alone. After 3 months of follow-up, the infarct region (determined by left ventriculography) had decreased significantly within the cell therapy group (from 30 ± 13 to $12 \pm 7\%$, $P=0.005$) and was also significantly smaller compared with the standard therapy group ($P=0.04$). Likewise, infarction wall movement velocity increased significantly only in the cell therapy group (from 2.0 ± 1.1 to 4.0 ± 2.6 cm/s, $P=0.028$). Further cardiac examinations (dobutamine stress echocardiography, radionuclide ventriculography, and catheterization of the right heart) were performed for the cell therapy group and showed significant improvement in stroke volume index, left ventricular end-systolic volume and contractility (ratio of systolic pressure and end-systolic volume), and myocardial perfusion of the infarct region.

Conclusions—These results demonstrate for the first time that selective intracoronary transplantation of autologous, mononuclear BMCs is safe and seems to be effective under clinical conditions. The marked therapeutic effect may be attributed to BMC-associated myocardial regeneration and neovascularization. (*Circulation*. 2002;106:1913-1918.)

Key Words: myocardial infarction ■ cell transplantation, intracoronary ■ angiogenesis ■ bone marrow ■ myogenesis

Remodeling of the left ventricle after myocardial infarction (MI) represents a major cause of infarct-related heart failure and death. This process depends on acute and chronic transformation of both the necrotic infarct region and the non-necrotic, peri-infarct tissue.^{1,2} Despite application of pharmacotherapeutics and mechanical interventions, the cardiomyocytes lost during MI cannot be regenerated. The recent finding that a small population of cardiac muscle cells is able to replicate itself is encouraging but is still consistent with the concept that such regeneration is restricted to viable myocardium.³

In animal experiments, attempts to replace the necrotic zone by transplanting other cells (eg, fetal cardiomyocytes or skeletal myoblasts) have invariably succeeded in reconstituting heart muscle structures, ie, myocardium and coronary vessels. However, these cells fail to integrate structurally and do not display characteristic physiological functions.⁴⁻⁷ Another approach to reverse myocardial remodeling is to repair myocardial tissue by using bone marrow–derived cells. Bone

marrow contains multipotent adult stem cells that show a high capacity for differentiation.⁸⁻¹⁰ Experimental studies have shown that bone marrow cells (BMCs) are capable of regenerating infarcted myocardium and inducing myogenesis and angiogenesis; this leads in turn to amelioration of cardiac function in mice and pigs.¹¹⁻¹⁴ However, procedures based on this phenomenon remain largely uninvestigated in a human clinical setting.

An investigation of one patient receiving autologous skeletal myoblasts into a postinfarction scar during coronary artery bypass grafting revealed improvement of contraction and viability 5 months afterward.¹⁵ Autologous mononuclear BMCs transplanted in a similar surgical setting showed long-term improvement of myocardial perfusion in 3 of 5 patients and no change in 2 patients.¹⁶ However, such studies entail a surgical approach and are therefore associated with well-known perioperative risks. Moreover, this surgical procedure cannot be used with MI. We therefore looked for a nonsurgical, safer mode for transplanting autologous cells

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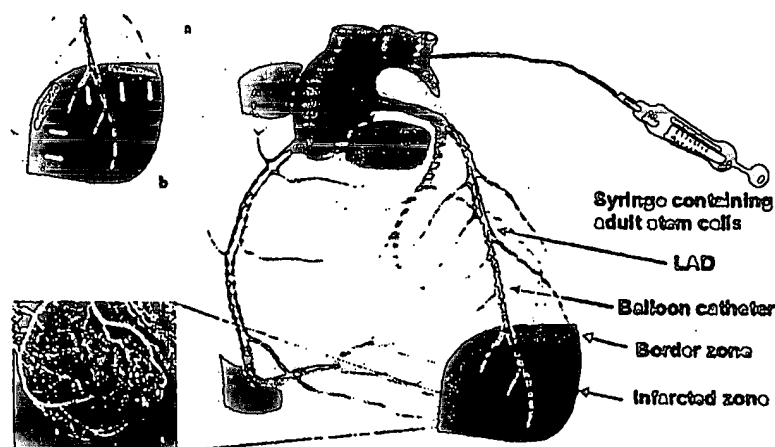


Figure 1. Procedure of cell transplantation into infarcted myocardium in humans. *a*, The balloon catheter enters the infarct-related artery and is placed above the border zone of the infarction. It is then inflated and the cell suspension is infused at high pressure under stop-flow conditions. *b*, In this way, cells are transplanted into the infarcted zone via the infarct-related vasculature (red dots). Cells infiltrate the infarcted zone. Blue and white arrows suggest the possible route of migration. *c*, A supply of blood flow exists within the infarcted zone.³⁸ The cells are therefore able to reach both the border and the infarcted zone.

into postinfarction tissue. A pilot study from our group demonstrated that intracoronary transplantation of autologous mononuclear BMCs 6 days after MI was associated with a marked decrease in infarct area and an increase in left ventricular (LV) function after 3 and 6 months of follow-up.¹⁷ To confirm these results and validate this promising new therapy for MI, we established a clinical trial involving 20 patients for comparing the safety and bioefficacy of autologous BMC transplantation. All 20 patients underwent standard therapy, and 10 patients received additional intracoronary cell transplantation. All 20 patients were followed up for 3 months.

Methods

Patient Population

All 20 patients had suffered transmural infarction according to World Health Organization criteria with the involvement of the left anterior descending coronary artery ($n=4$), left circumflex coronary artery ($n=3$), or right coronary artery ($n=13$). Mean duration of infarct pain was 12 ± 10 hours before invasive diagnostics and therapy. Patients had to be <70 years old and were excluded if one of the following criteria were met: screening >72 hours after infarction, cardiac shock, severe comorbidity, alcohol or drug dependency, or excessive travel distance to the study center.

After right and left heart catheterization, coronary angiography, and left ventriculography, mechanical treatment was initiated with recanalization of the infarct-related artery by balloon angioplasty ($n=20$) and subsequent stent implantation ($n=19$). All patients were monitored in our intensive care unit, and no arrhythmogenic events or hemodynamic impairments were recorded in either patient group.

All 20 patients were briefed in detail about the procedure of BMC transplantation. Informed consent was obtained from 10 patients, who formed the cell therapy group, whereas 10 patients who refused additional cell therapy served as controls. The local ethics committee of the Heinrich-Heine-University, Düsseldorf, approved the study protocol. All procedures conformed to institutional guidelines.

Before taking part in rehabilitation programs, all patients left the hospital with standard medication consisting of acetylsalicylic acid, an ACE inhibitor, a β -blocker, and a statin.

Bone Marrow Aspiration, Isolation, and Cultivation

Seven (± 2) days after acute coronary angiography, bone marrow (~ 40 mL) was aspirated under local anesthesia from ilium of cell therapy patients ($n=10$). Mononuclear BMCs were isolated by Ficoll density separation on Lymphocyte Separation Medium (BioWhittaker) before the erythrocytes were lysed with H_2O . For overnight

cultivation, 1×10^6 BMCs/mL were placed in Teflon bags (Vuelife, Cell Genix) and cultivated in X-Vivo 15 Medium (BioWhittaker) supplemented with 2% heat-inactivated autologous plasma. The next day, BMCs were harvested and washed 3 times with heparinized saline before final resuspension in heparinized saline. Viability was $93 \pm 3\%$. Heparinization and filtration (cell strainer, FALCON) was carried out to prevent cell clotting and microembolization during intracoronary transplantation. The mean number of mononuclear cells harvested after overnight culture was 2.8×10^7 ; this consisted of $0.65 \pm 0.4\%$ AC133-positive cells and $2.1 \pm 0.28\%$ CD34-positive cells. All microbiological tests of the clinically used cell preparations proved negative. As a viability and quality *ex vivo* control, 1×10^5 cells grown in H5100 medium (Stem Cell Technology) were found to be able to generate mesenchymal cells in culture.

Intracoronary Transplantation of BMCs

Five to nine days after onset of acute infarction, cells were directly transplanted into the infarcted zone (Figure 1). This was accomplished with the use of a balloon catheter, which was placed within the infarct-related artery. After exact positioning of the balloon at the site of the former infarct-vessel occlusion, percutaneous transluminal coronary angioplasty (PTCA) was performed 6 to 7 times for 2 to 4 minutes each. During this time, intracoronary cell transplantation via the balloon catheter was performed, using 6 to 7 fractional high-pressure infusions of 2 to 3 mL cell suspension, each of which contained 1.5 to 4×10^6 mononuclear cells. PTCA thoroughly prevented the backflow of cells and at the same time produced a stop-flow beyond the site of the balloon inflation to facilitate high-pressure infusion of cells into the infarcted zone. Thus, prolonged contact time for cellular migration was allowed.¹⁰

Functional Assessment of Hemodynamics

After 3 months, all 20 patients were followed up by left heart catheterization, left ventriculography, and coronary angiography. Ejection fraction, infarct region, and regional wall movement of the infarcted zone during ejection were determined by left ventriculography. Ejection fraction was measured with Quantcor software (Siemens). To quantify infarction wall movement velocity, 5 axes were placed perpendicular to the long axis in the main akinetic or dyskinetic segment of the ventricular wall. Relative systolic and diastolic lengths were measured, and the mean difference was divided by the systolic duration (in seconds). To quantify the infarct region, the centerline method according to Sheehan was used.¹⁹ All hemodynamic investigations were obtained by two independent observers.

In the cell therapy group before and 3 months after cell transplantation, additional examinations for measuring hemodynamics and myocardial perfusion included dobutamine stress echocardiography, radionuclide ventriculography, catheterization of the right heart, and

TABLE 1. Baseline Characteristics of the Patients

| Clinical Data | Cell Therapy | Standard Therapy | P |
|---|--------------|------------------|-----|
| Characteristics | | | |
| No. of patients | 10 | 10 | ... |
| Age, y | 49±10 | 50±6 | NS |
| Sex | Male | Male | ... |
| Onset of Infarction before angioplasty, h | 10±8 | 13±11 | NS |
| Coronary angiography | | | |
| No. of diseased vessels | 1.7±0.9 | 2.1±0.7 | NS |
| No. of patients with LAD/LCX/RCA as the affected vessel | 4/1/5 | 0/2/8 | ... |
| No. of patients with stent implantation | 9 | 10 | ... |
| Laboratory parameters | | | |
| Creatinine kinase, U/L | 1138±1170 | 1308±1187 | NS |
| Creatinine kinase-MB, U/L | 106±72 | 124±92 | NS |
| Bone marrow puncture after angioplasty, d | 7±2 | ... | ... |
| Mononuclear bone marrow cells, n (×10 ³) | 2.8±2.2 | ... | ... |

Values are mean±SD or number of patients.

NS indicates not significant; LAD, left anterior descending coronary artery; LCX, left circumflex coronary artery; and RCA, right coronary artery.

stress-redistribution-reinjection ²⁰¹thallium scintigraphy. The contractility index $P_{\text{myo}}/\text{ESV}$ was calculated by dividing LV systolic pressure (P_{myo}) by end-systolic volume (ESV). Perfusion defect was calculated by scintigraphic bull's-eye technique. Each examination was performed according to standard protocols.

There were no complications or side effects determined in any patient throughout the diagnostic or therapeutic procedure or within the 3-month follow-up period.

Statistical Analysis

All data are presented as mean±SD. Statistical significance was accepted when P was <0.05. Discrete variables were compared as rates, and comparisons were made by χ^2 analysis. Intra-individual comparison of baseline versus follow-up continuous variables was performed with a paired t test. Comparison of nonparametric data between the two groups was performed with Wilcoxon test and Mann-Whitney test. Statistical analysis was performed with SPSS for Windows (version 10.1).

Results

Clinical data between the two groups did not differ significantly. The range of creatinine kinase levels was slightly but not significantly higher in the standard therapy group than it was in the cell therapy group (Table 1).

Comparison of the 2 groups 3 months after cell or standard therapy showed several significant differences in LV dynamics, according to the global and regional analysis of left ventriculogram. The infarct region as a percentage of hypokinetic, akinetic, or dyskinetic segments of the circumference of the left ventricle decreased significantly in the cell therapy group (from 30±13 to 12±7%, $P=0.005$). It was also significantly smaller compared with the standard therapy group after 3 months ($P=0.04$). Within the standard therapy group, only a statistically nonsignificant decrease from 25±8 to 20±11% could be seen. Wall movement velocity over the infarct region rose significantly in the cell therapy group (from 2.0±1.1 to 4.0±2.6 cm/s, $P=0.028$) but not in the standard therapy group (from 1.8±1.3 to 2.3±1.6 cm/s, $P=NS$). No significant difference was observed between the

two groups. Ejection fraction increased in both groups, albeit nonsignificantly (from 57±8 to 62±10% in the cell therapy group and from 60±7 to 64±7% in the standard therapy group) (Table 2).

Further significant improvement could also be seen on additional analysis of the cell therapy group alone. Perfusion defect was considerably decreased by 26% in the cell therapy group (from 174±99 to 128±71 cm², $P=0.016$, assessed by ²⁰¹thallium scintigraphy) (Figure 2). Parallel to the reduction in perfusion defect, improvement (Table 3) could also be seen in:

- (1) Cardiac function, as revealed by increase in stroke volume index (from 49±7 to 56±7 mL/m², $P=0.010$) and ejection fraction (from 51±14 to 53±13%, $P=NS$).
- (2) Cardiac geometry, as shown by decreases in both end-diastolic (from 158±20 to 143±30 mL, $P=NS$) and end-systolic volume (from 82±26 to 67±21 mL, $P=0.011$). Radionuclide ventriculography was used to acquire the data.
- (3) Contractility as evaluated by an increase in the velocity of circumferential fiber shortening (from 20.5±4.2 to 24.4±7.7 mm/s, $P=NS$, assessed by stress echocardiography) and by a marked increase in the ratio of systolic pressure to end-systolic volume (from 1.81±1.44 to 2.27±1.72 mm Hg/mL, $P=0.005$).

Discussion

The present report describes the first clinical trial of intracoronary, autologous, mononuclear BMC transplantation for improving heart function and myocardial perfusion in patients after acute MI. The results demonstrate that transplanted autologous BMCs may lead to repair of infarcted tissue when applied during the immediate postinfarction period. These results also show that the intracoronary approach of BMC transplantation seems to represent a novel

TABLE 2. Comparison of Cell Therapy and Standard Therapy Groups

| | Cell Therapy | Standard Therapy | P |
|--|--------------|------------------|------|
| No. of patients | 10 | 10 | ... |
| Infarct region as functional defect | | | |
| Hypokinetic, akinetic, or dyskinetic region at 0 mo, % | 30±13 | 25±8 | NS |
| Hypokinetic, akinetic, or dyskinetic region at 3 mo, % | 12±7 | 20±11 | 0.04 |
| P | 0.005 | NS | ... |
| Contractility indices | | | |
| Infarction wall movement velocity at 0 mo, cm/s | 2.0±1.1 | 1.8±1.3 | NS |
| Infarction wall movement velocity at 3 mo, cm/s | 4.0±2.6 | 2.3±1.6 | NS |
| P | 0.028 | NS | ... |
| Hemodynamic data | | | |
| LV ejection fraction at 0 mo, % | 57±8 | 60±7 | NS |
| LV ejection fraction at 3 mo, % | 62±10 | 64±7 | NS |
| P | NS | NS | ... |

NS indicates not significant; 0 mo, zero months, which means the time of infarction; 3 mo, 3 months, which means the time of the follow-up examinations. All data were obtained according to analysis of left ventriculogram.

and effective therapeutic procedure for concentrating and/or depositing infused cells within the region of interest.

Neogenesis of both cardiomyocytes and coronary capillaries with some functional improvement has been shown recently by several investigators using bone marrow-derived cells in experimental infarction.^{11-14,18,20-23} Moreover, trans-endothelial migration from the coronary capillaries and incorporation of cells into heart muscle has been observed experimentally.^{3,12,24-26} Until now, clinical data only existed for the cell therapy of surgically treated chronic ischemic heart disease.^{15,16} Our aim was to transform the encouraging results from animal models to a safe clinical setting. The most crucial questions we had to address while designing and

realizing this trial were: (1) What cell population should we deliver? (2) Which application method is the most efficient? (3) When should the cells be transplanted?

In recent years, several laboratories have shown that environmentally dictated changes of fate (transdetermination) are not restricted to stem cells but may also involve progenitor cells at different steps of a given differentiation pathway (transdifferentiation). Moreover, mesenchymal stem cells may represent an ideal cell source for treating different diseases.²⁷ Adult, mononuclear BMCs contain such stem and progenitor cells ($\leq 1\%$), eg, mesodermal progenitor cells, hematopoietic progenitor cells, and endothelial progenitor cells. In several animal infarction models it has been shown that: (1) Bone marrow hemangioblasts contribute to the formation of new vessels; (2) bone marrow hematopoietic stem cells differentiate into cardiomyocytes, endothelium,

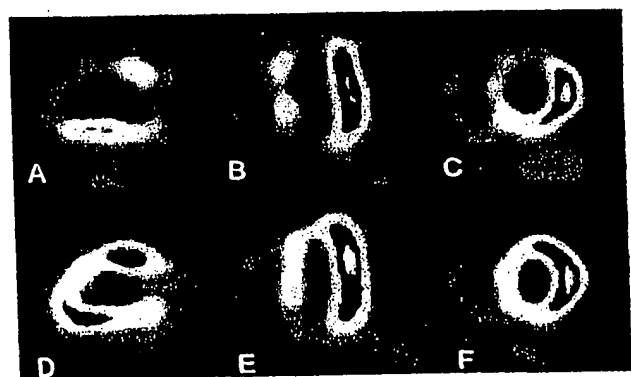


Figure 2. Improved myocardial perfusion of infarcted anterior wall 3 months after intracoronary cell transplantation subsequent to an acute anterior wall infarction detected by ²⁰¹thallium scintigraphy. The images on the left (A, D, sagittal) and in the middle (B, E) show the long axis, whereas those on the right (C, F, frontal) show the short axis of the heart. Initially the anterior wall, with green-colored apical and anterior regions, had reduced myocardial perfusion (A, B, C). Three months after cell transplantation the same anterior wall, now yellow in color, revealed a significant improvement in myocardial perfusion (D, E, F). All illustrations depict the exercise phase.

TABLE 3. Cardiac Function Analysis at 3-Month Follow-Up

| | Before Cell Therapy | 3 Months After Cell Therapy | P |
|---|---------------------|-----------------------------|-------|
| No. of patients | 10 | 10 | ... |
| Hemodynamic data | | | |
| LV ejection fraction, % | 51±14 | 53±13 | NS |
| Stroke volume index, mL/m ² | 49±7 | 56±7 | 0.010 |
| Cardiac geometry | | | |
| LV end-diastolic volume, mL | 158±20 | 143±30 | NS |
| LV end-systolic volume, mL | 82±26 | 67±21 | 0.011 |
| Contractility indices | | | |
| Circumferential fiber shortening, mm/s | 20.5±4.2 | 24.4±7.7 | NS |
| P _{max} /ESV, mm Hg/mL | 1.81±1.44 | 2.27±1.72 | 0.005 |
| Infarct region as perfusion defect | | | |
| ²⁰¹ Thallium scintigraphy, cm ² | 174±99 | 128±71 | 0.016 |

NS indicates not significant.

and smooth muscle cells¹³; (3) BMCs give rise to mesodermal progenitor cells that differentiate to endothelial cells²⁸; and (4) endothelial progenitors can transdifferentiate into beating cardiomyocytes.²⁹ Thus, several different fractions of mononuclear BMCs may contribute to the regeneration of necrotic myocardium and vessels. In order to utilize this large and perhaps heterogeneous regenerative potential, we decided to use all mononuclear cells from the bone marrow aspirate as a whole, rather than a subpopulation. No further expansion was performed because experimental data have revealed a dramatic decline in the homing capacity of *in vitro* amplified hematopoietic stem or progenitor cells.³⁰

The second question was how to deliver the cells most efficiently. When given intravenously, only a very small fraction of infused cells can reach the infarct region after the following injection: assuming a normal coronary blood flow of 80 mL/min per 100 g of LV weight, a quantity of 160 mL per left ventricle (assuming a regular LV mass of ~200 g) will flow per minute.^{31,32} This corresponds to only about 3% of cardiac output (assuming a cardiac output of 5000 mL/min).³¹ Therefore, intravenous application would require many circulation passages to enable infused cells to come into contact with the infarct-related artery. Throughout this long circulation and recirculation time, homing of cells to other organs could considerably reduce the numbers of cells dedicated to cell repair in the infarcted zone. Thus, supplying the entire complement of cells by intracoronary administration obviously seems to be advantageous for the tissue repair of infarcted heart muscle and may also be superior to intraventricular injection,³³ because all cells are able to flow through the infarcted and peri-infarcted tissue during the immediate first passage. Accordingly, by this intracoronary procedure the infarct tissue and the peri-infarct zone can be enriched with the maximum available amount of cells at all times.

As stem cells differentiate into more mature types of progenitor cells, it is thought that a special microenvironment in so-called niches regulates cell activity by providing specific combinations of cytokines and by establishing direct cellular contact. For successful long-term engraftment, at least some stem cells have to reach their niches, a process referred to as homing. Mouse experiments have shown that significant numbers of BMCs appear in liver, spleen, and bone marrow after intravenous injection.³⁴ To offer the BMCs the best chance of finding their niche within the myocardium, a selective intracoronary delivery route was chosen. Presumably, therefore, fewer cells were lost by extraction toward organs of secondary interest by this first pass-like effect. To facilitate transendothelial passage and migration into the infarcted zone, cells were infused by high-pressure injection directly into the necrotic area, and the balloon was kept inflated for 2 to 3 minutes; the cells were not washed away immediately under these conditions.

The time point for delivery was chosen as 7 to 8 days after infarction onset for the following reasons:

- (1) In dogs, infarcted territory becomes rich in capillaries and contains enlarged, pericyte-poor "mother vessels" and endothelial bridges 7 days after myocardial ischemia and reperfusion. Twenty-eight days later, a significant muscular vessel wall has already formed.³⁵ Thus, with such timing, cells may be able to reach the worst

damaged parts and at the same time salvage tissue. Transendothelial cell migration may also be enhanced because an adequate muscular coat is not yet formed.

- (2) Until now, only one animal study has attempted to determine the optimum time for cardiomyocyte transplantation to maximize myocardial function after LV injury. Adult rat hearts were cryoinjured and fetal rat cardiomyocytes were transplanted immediately, 2 weeks later, and 4 weeks later. The authors discussed the inflammatory process, which is strongest in the first days after infarction, as being responsible for the negative results after immediate cell transplantation, and they assumed that the best results seen after 2 weeks may have been due to transplantation before scar expansion.³⁶ Until now, however, no systematic experiments have been performed with BMCs to correlate the results of transplantation with the length of such a time delay.
- (3) Another important variable is the inflammatory response in MI, which seems to be a superbly orchestrated interaction of cells, cytokines, growth factors and extracellular matrix proteins mediating myocardial repair. In the first 48 hours, debridement and formation of a fibrin-based provisional matrix predominates before a healing phase ensues.³⁷⁻⁴⁰ Moreover, vascular endothelial growth factor is at its peak concentration 7 days after MI, and the decline of adhesion molecules (intercellular adhesion molecules, vascular cell adhesion molecules) does not take place before days 3 to 4 after MI. We assumed that transplantation of mononuclear BMCs within the "hot" phase of post-MI inflammation might lead them to take part in the inflammation cascade rather than the formation of functional myocardium and vessels.

Taking all of this into account, we can conclude that cell transplantation within the first 5 days after acute infarction is not possible for logistical reasons and is not advisable because of the inflammatory process. On the other hand, transplantation 2 weeks after infarction scar formation seems to reduce the benefit of cell transplantation. Although the ideal time point for transplantation remains to be defined, it is most likely between days 7 and 14 after the onset of MI, as in the present study.

This trial was designed as a phase I safety and feasibility trial, meaning that no control group is necessarily required. However, to validate the results, we correlated them with those obtained from 10 patients who refused to get additional cell therapy and thus received standard therapy alone. We are aware of the fact that such a comparison does not reach the power of a randomly allocated, blinded control group. However, the significant improvement with regard to infarct region, hemodynamics (stroke volume index), cardiac geometry (LV end-systolic volume), and contractility ($P_{1/2}/ESV$ and infarction wall movement velocity) did confirm a positive effect of the additional cell therapy because the changes observed in the standard therapy group failed to reach significance.

Another important factor for interpreting the results is time interval between onset of symptoms and revascularization of the infarct-related artery by angioplasty; this represents a crucial determinant of LV recovery. For patients with acute MI, it has

been shown that if the time interval is >4 hours, no significant changes in ejection fraction, regional wall motion, or ESV are observed after 6-month follow-up by echocardiography and angiography.⁴¹ None of our 20 patients was treated by angioplasty within 4 hours after onset of symptoms. Our average time interval was 12 ± 10 hours. Thus, PTCA-induced improvement of LV function can be nearly excluded; indeed, the only mild and nonsignificant changes within the standard therapy group are consistent with the above-mentioned data.⁴¹ In contrast, the cell therapy group showed considerable and significant improvement in the same parameters, which may be attributed to BMC-mediated coronary angiogenesis and cardiomyoneogenesis.

These results show that transplantation of autologous BMCs, as well as the intracoronary approach, represent a novel and effective therapeutic procedure for the repair of infarcted myocardium. For this method of therapy, no ethical problems exist, and no side effects were observed at any point of time. The therapeutic benefit for the patient's heart seems to prevail. However, further experimental studies, controlled prospective clinical trials, and variations of cell preparations are required to define the role of this new approach for the therapy of acute MI in humans.

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